AIDS

HIV tests are not HIV tests - Dr. Henry H. Bauer, Ph.D.

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Abstract

Tests for human immunodeficiency virus "HIV" do not detect "HIV"; they react "positively" to a wide range of physiological conditions. Historical documents in Gallo's laboratory have not shown that "HIV" is the cause of AIDS. The patent based on those documents did not show that the proposed tests for "HIV" (tests for "HIV" antibodies) were specific for "HIV" antibodies.

From the initial announcement that "HIV is the probable cause of AIDS" to the statement that "HIV antibodies demonstrate active HIV infection" we are dealing with an unjustified evolution that has taken place almost subliminally. "HIV" test kits have only been approved for blood screening and **none claim to diagnose an infection** . There is no "gold standard" for the "HIV" test; current tests are at most complementary to the clinical diagnosis of an "HIV" infection.

The consequences of the abusive application of "HIV" tests represent for healthy people the risk of iatrogenic injuries (caused by doctors) and can lead to the administration of extremely toxic drugs for the rest of their lives.

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If you're right and you know it. s*

Introduction

It has never been shown that so-called "HIV tests" could detect any infection with "HIV" (human immunodeficiency virus, a retrovirus) , although for over a quarter of a century these tests have been used globally to diagnose such an infection. [1] Test kit manufacturers do not claim that the tests detect any infection.

The tests are for antibodies [2] and are approved only for blood analysis and screening, their primary criterion is *sensitivity* and not *specificity* , so false-positive results are not very important. Technical debates [3] on how to detect an "HIV" infection clearly show that tests, as a stand-alone tool, are insufficient to diagnose an infection.

In reality, a "positive" result for "HIV" can be the result of many medical history, such as hypergammaglobulinemia, tuberculosis, influenza vaccination [4] , administration of tetanus immunoglobulin [5-6] and even pregnancy. [7-9]

The story behind these circumstances has several chapters:

1. *Alleged* discovery or identification of a retroviral cause for AIDS;
2. The patented method for detecting *alleged* HIV-specific antibodies , representing an *alleged* "HIV" test;
3. Extrapolating the claim that "HIV" tests would detect antibodies until it was assumed that a "positive" result would be evidence of an "HIV" infection;
4. In the absence of any "gold standard", the use of the first antibody test (non-standardized, non-validated) as the basis for the presumed validation for all subsequent tests (a "gold standard" could only be obtained based on data on pure virions of " HIV "obtained from an individual tested positive" HIV "-> *that there is no single - nt*).

Putting the equal sign between a "positive" test and an "HIV infection" has the worst consequences: many healthy people who at some point happen to be tested "positive" with these non-standardized "HIV" tests have suffered serious physical, mental and financial damage.

In the following, when I cite older papers involving the original terminology of "human T-lymphotropic virus" (HTLV-III) and lymphadenopathy-associated virus (LAV), these terms will be used instead of the term "HIV."

Announcement of the discovery of a retrovirus that would cause AIDS

"HTLV-III is the probable cause of acquired immunodeficiency syndrome

truth is still the truth .
Mahatma Gandhi

Gallo. Four *subsequent* articles in the journal Science revealed the basis of that statement.

Popovic et al. [10] described a line of T cells made "immortal", in which large amounts of "HTLV-III" could be cultured by co-cultivation with *supposedly* infected T cells . It was claimed that a retrovirus had been detected by the presence of reverse transcriptase (*RT*). The activity lapel s transcriptase was chosen criterion based on which a sucrose density of 1.6 g / ml for "band" in which *it was said* that the virus was found ultracentrifugation.

The problem is that the *reverse transcriptase is present in all normal cells* [11,12] , which cancels a central element of works complicated r iiGallo / Popovic as well as in subsequent research on "HIV". It was claimed that electron microscopy would show a large amount of "extracellular viral particles"; but this could have been demonstrated only by the isolation and purification of these particles, establishing with certainty that these particles were indeed virions, which was never done. It is also said that the virus was detected by the antigen-antibody reaction, but this implies a tautology (unnecessary repetition of the same idea, in other words). As I will explain below, "isolation is not isolation," "purification is not purification."

It was also claimed that HTLV-III proteins were found in the serum of 85% of AIDS patients and that HTLV-III was related to HTLV-I and HTLV-II, retroviruses previously discovered by Gallo. In contrast, LAV virus, originally described by Barré-Sinoussi and Montagnier, had nothing to do with HTLV-I and HTLV-II, and antibodies to LAV were present in only 37.5% of sera collected from AIDS patients. All these statements proved to be false.

HTLV-III was actually LAV, of which Montagnier had sent a sample to Gallo, who used it as his own. Thus, in 2009 the Nobel Prize was awarded only to Montagnier and Barré-Sinoussi, Gallo being excluded. Many other mistakes and fissures were discovered in the activity of Gallo's laboratory, he himself managed only to escape the official accusation of "scientific fraud" due to a technical detail. [13]

In another article, Gallo et al. [14] a u claimed to have isolated HTLV-III from 26 of 72 patients with AIDS, 18 of the 21 patients with "pre-AIDS", 3 of 4 healthy mothers of children with AIDS and one of the 22 "normal homosexual subjects". However, as a disease worsens, more active pathogens are expected to be found, so it is very strange that this "leading cause of AIDS" could only be found in 36% of patients in the active disease phase. , while it would have been detected in 85% of those with "pre-AIDS"!

In addition, the "pre-AIDS" symptoms were fever and chronic inflammation of the lymph nodes, symptoms that are found in many other diseases that are not specific "precursors" for AIDS; these symptoms are considered to be precursors to AIDS only when they occur in people in the "risk categories", homosexuals or intravenous drug users. In addition, the term "isolation" is used fraudulently, see below.

A third article published in the same period [1 5] again claimed that HTLV-III was "a true member of the HTLV retrovirus family", but " … *which can be clearly distinguished from HTLV-I and HTLV-II.* ". Some were some unclear statements about what kind of antigen E had been associate you with that of those retroviruses. Thus, p61 and p65 would be "encoded by HTLV-I", but often identified by the serum of AIDS patients. HTLV-III antigens would be " *similar in size* " to those of other "HTLV" viruses, but would include three " *separate serological* " groups : p55 and p24, which would be " *group-specific* "." p65, which would be related to the viral envelope; plus a third group of "unknown affiliates". Another passage in the article states that " *antibodies to the protein structures of HTLV, especially p24 and p19… are not detectable in*

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OUTSIDE THE MATRIX

obvious antigens " of HTLV-III, which would be " *p65, p60, p55, p41 and p24* "; it was claimed that the less obvious antigens were p88, p80, p39, p32, p28, and p21. Some cross-reactions of p65 with HLTV-I have been admitted, as have cross-reactions with nonspecific antigens associated with the Gag protein. However, it was claimed that p65, p55, p41, p39, p32, and p24 were specific and " *newly manifested after viral infection* "; but this obviously does not rule out the possibility that these antigens may be correlated with other "agents" besides HTLV-III.

It is obvious that immunological abnormalities found in AIDS patients also occur in people suffering from, for example, tuberculosis, diabetes, malaria, macroglobulinemia, aplastic anemia or thalassemia; it is also obvious that these abnormalities can be induced by adrenaline, prednisone or Epstein-Barr virus. [16]

The fourth article [17] reported that HTLV-III antigens would have reacted with the serum of 88% of AIDS patients and 79% of homosexuals with pre-AIDS symptoms as well as less than 1% of heterosexual subjects. This time, maximum reactivity was claimed for p41, a putative viral envelope antigen. Note: HTLV-III antigens reacted in the serum of 88% of AIDS patients, although HTLV-III had been "found" only in the serum of 36% of patients.

It has already been pointed out several times in the literature that this article was far from proving that HTLV-III was the necessary and sufficient cause of AIDS; we quote: "the *data presented do not prove the isolation of any retrovirus, they do not prove that the virus is exogenous or that the virus is causally linked to AIDS.* " [18] Indeed," masterpiece "of Gallo was in fact a circular argument [19] [20] has been shown that antibodies in sera from patients with AIDS and" pre-AIDS "react with cellular material from the cultures infected with some unidentified agents from the serum of AIDS and AIDS subjects [*exactly what had previously been introduced into Gallo's secret cultures was detected - nt*]. However, the most serious drawback of the study was that no similar reactivity was shown for other physiological conditions or other conditions than AIDS, and subsequent studies did reveal many situations in which HIV tests showed "false positive results." " [4-9]

Patent for virus detection

U.S. Patent 4,520,113 to Robert Gallo and colleagues Mikulas Popovic and Mangalasseril G. Sarngadharan on May 28, 1985, claimed that " *antigens associated with infection of human cells with this virus would be identified as specific by antibodies to patients with AIDS. Expressly, HTLV-III isolated from AIDS patients and transmitted by co-cultivation with an HT cell line would have been specifically detected by human serum antibodies taken from AIDS patients.* "

The test is not specific

This new test was very unsafe and ineffective, given that it tested positive in 88% of AIDS patients and 79% of homosexuals with "pre-AIDS", but especially considering that "positive" reactions were also found in donors. blood (uninfected) [17] , as such it was clear from the outset that the test was not specific at all.

One reason is that the p41 protein is the most typical and prominent HIV-specific antigen and that p65, p60, p55 and p24 " *were not detected in normal serum* ". However, antibodies to p24 have been found in many patients with multiple sclerosis, T-cell lymphoma and generalized warts. [21] Moreover, at ca. 15% of healthy blood donors, p24 was the "predominant band" in Western Blot tests, and the so-called p41 transmembrane protein was also found in the platelets of healthy individuals. [18]

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Isolation is not isolation; purification is not purification

In the patent documentation, as in previous articles in "Science", as well as in all the "HIV" / AIDS literature so far, "isolation" and "purification" do not have the meaning that these two terms have in ordinary language, namely, that "isolation" means the extraction of that particle from the natural environment (in this case from the serum of a patient diagnosed as positive for "HIV"!), and "purification" means the removal of all foreign, contaminating elements from "isolated" particles. in order to obtain in the end only the desired structure (in our case, "HIV").

So no, in the jargon of "HIV" / AIDS, "isolation" and "purification" do not mean the isolation and purification of "HIV" from an AIDS patient or an individual diagnosed with "HIV." On the contrary, a patient's leukocytes are first cultured with T cells from an "immortal" line originally established by Gallo, who used additional stimulants such as phytohemagglutinin or IL-2, which were thought to cause cell cultures to "manifest" virus.

It is claimed that "isolation" was performed if:

1 - the culture has an RT (reverse transcriptase) activity - which we now know is not specific to retroviruses [11] [12] or
2 - when an extract from this culture is able to do what the original sample did, ie to "infect" other cultures.

Such a procedure does not prove the presence of any virion in the original sample collected from humans: any authentic virion present in the culture could be just as well generated by the method of cultivation. It cannot be ruled out that a culture produces *ab initio* a structure that can generate a positive response to the "HIV" test. Normal human genomes include some DNA sequences similar to what appears to be "HIV", and this can be manifested by certain cultivation techniques such as those used in "HIV" / AIDS research. [18]

"Purification" in "HIV" / AIDS jargon means that the material supposed to contain "HIV" is ultracentrifuged in a specially prepared medium and certain sediments that are deposited at a certain density are considered to be "HIV". Published electron micrographs of such a so-called "isolated" and "purified" structure actually show a motley mixture of unidentified cell particles. It is obvious that they do not contain pure virions, and there is no evidence that they contain at least one virion. [22] [23]

Gallo even claimed that there would be no need to purify "HIV" because his cultivation method produced so much "HIV" (quantitative) that it didn't matter what else it contained!

In 2009, at the trial in Australia, Gallo said something else:

" *Purification must be performed… […] A retrovirus emerges from the cell membrane and thereby incorporates certain cellular proteins into the virus. Putting the virus in the sucrose gradient (the sugar-based medium used in the ultra-centrifugation process) will do nothing if you have just a little virus. So the ratio of cellular material to virus… I don't mean to be an exact figure, but I will give an example. If the ratio is 1000 to 1 and you manage to mass produce the virus in a continuous culture, then you get an enormous purification, much higher than the sucrose gradient, because now you produce huge amounts of virus with small amounts of cells.* " [24]

This claim that a large amount of the alleged virus in relation to cellular waste would be as good or better than obtaining the purified virus is not

Statements passed in silence

A number of claims in Gallo's patent for the "HIV" test have been silently forgotten. For example, the statement that there would be an obvious cross-reaction with Gallo's HTLV-I and HTLV-II. Gallo had previously reported the isolation of HTLV-I in an AIDS patient [25] and described HTLV-I and HTLV-II as "the only known AIDS-specific co-factors." [26]

The patent attributes to the p41 protein the main specificity of the assay, plus some reactivity for p65, p60, p55 and p24. But current Western Blot criteria include p160, p120, p68, p55, p53, p41, p39, p32, p24 and p18; so only three of the five antigens that Gallo defined as specific for "HIV" appear among the 10 antigens currently thought to be specific for "HIV"; In addition, seven other completely new antigens appear (compared to Gallo's patent).

Worse, even now it has not been agreed on which combination of these proteins is supposed to be specific for "HIV". [27]

For example, in Africa, if two of the p160, p120 or p41 proteins fail the test, the test is considered "positive". On the other hand, in Australia one of the above proteins is needed together one of the 3 pol proteins (p68, p53, p32) or the antibodies to the gag proteins (p55, p39, p24, p18), in Germany it is needed ONE of the p160, p120 or p41 proteins together with any of the pol or gag proteins, and in England ONE of the p160, p120 or p41 proteins together with p32 or p24 [have *n't you taken the dizziness of so much "specificity" yet ?? - nt*]. In France, for a test to be considered positive, it takes ALL 3 (p160, p120 and p41), along with any of the pol proteins, plus any of the gag proteins. In the USA, five different criteria were used depending on the different risk groups!

Arbitrary criteria for "positive" result

The "enzyme-linked immunosorbent assay" ELISA, the basic test for antibodies, measures chromatic intensity. However, the tests in the control groups are never completely colorless. The only objective way to identify a chromatic intensity that would correspond to the total, guaranteed absence of the alleged antibodies against "HIV" would be to have samples from people who are known to be 100% sure that they have never been exposed to "HIV", which which is impossible. The best method from a practical point of view, but recognized as imperfect, is to use blood from frequent donors as a "negative control". [3]

Example 1 of the patent reports that " *if an absorption of three times the average of 4 normal negatives is present, the test is considered to have a positive result.* "With this criterion, positive tests were obtained in 88% of AIDS patients [*HOW did they know how to diagnose AIDS without establishing 100% of the cause ?? - nt*], in 79% of those with pre-AIDS [*other speculation - nt*], in 60% of those who took drugs intravenously and in 27% of healthy homosexuals; up to 0.5% of control groups reacted "positively"

We cannot speak here of a safe, specific detection of any "factor" (whatever it may be) that is characteristic only of AIDS.

One of the people used as "control groups" could have had small amounts of "HIV" antibodies in the body, and the absorption three times higher than "normal" could be caused by cross-reactions. These possibilities cannot be ruled out.

And from other points of view, the patent is very little "impressive". Examples 1 and 4 both refer to the data shown in Table 1 and describe the

This is NOT an "HIV" test

In essence, the way this test was developed makes it at most a test for "AIDS" and "pre-AIDS", but not a test for "HIV" (ie a test that should be more sensitive to -AIDS than for AIDS). In addition, because pre-AIDS symptoms (swollen lymph nodes and fever) indicate many other possible conditions, the **test is obviously a nonspecific disease test** . Different patients with different conditions may react "positively" to the test. After the test has been used for a long time, it has been found that it can come out "positive" even in conditions that do not fall into the "disease" category, such as vaccination or pregnancy (pregnancy). [4] [9] [*A pregnant woman's blood samples should be diluted 40 times so as not to give false positive results on "HIV" tests - nt*]

Antibodies as an indicator of infection

It is clear that scientific publications and the patent for the test are insufficient to justify the claim that HTLV-III is "the probable cause of AIDS." Then how did a completely nonspecific antibody test come to be the basis for the sentence that a person was actively infected with "HIV"?

Rodney Richards, who worked on the development of the first "HIV" ELISA test (produced by Abbott Laboratories), provided a detailed timeline showing how the presence of antibodies came to be equated with an active infection. [28] The story might seem incredible, if not fully documented by official public domain material, quoted by Richards.

Initially, in 1984, the CDC had correctly accepted the possibility that the antibody test would give false-positive results " *due to an antigenic related virus or non-specific test factors* ." People with a high risk of "AIDS" were presumed to have previous exposure to the virus [*this is how allopathic medicine works, with many assumptions - nt*]; however, " *it is not known whether the person is actually infected or immune* ," and the *frequency of the virus in people with antibodies remains to be determined.* " [29]

Six months later, the CDC admitted that there was a high rate of false-positive results when screening normal blood tests on healthy, low-risk populations: no one was allowed to be informed of a positive result until a test was performed. two tests. [30]

Only three months later, the FDA approved Abbott's ELISA for normal blood tests. Of course, all necessary measures must be taken to detect the possible presence of a "pathogen" in the blood to be used for transfusions: it is better to dispose of 100 vials of healthy blood than to allow a transfusion with even a single sample of infected blood.

However, it is completely different to inform someone, based on an uncertain test, that they are infected with a fatal pathogen, against which there is no cure. The Abbott prospectus contained the appropriate disclaimer: "***There is no recognized standard for the presence or absence of "HIV-1" antibodies in human blood. The risk for an asymptomatic person who has a repeated reaction to serum samples to develop AIDS or similar conditions is not known.*** "The same disclaimers appear in the prospectus of the Western Blot test, approved in 1987 and widely used as a so-called confirmation of the ELISA test that comes out twice as positive. [28, p. 339] Similar disclaimers are found in virtually all tests to date. [1]

A few months after the Abbott test was approved for normal blood tests, blood donor data showed that 44% of the tests that tested positive for HIV antibodies did not contain any detectable virus in culture. Similarly, 40% of homosexuals tested positive for antibodies had no detectable virus. [31] In

This reality was "in the throat" of the CDC. The data clearly showed that in half of the cases the positive antibody test came in the absence of the virus. However, the CDC diverted attention to the other half and ruled: " *Because a large percentage of people with asymptomatic HIV are infected,* [5] it *must be assumed that all HIV-positive people, whether symptomatic or not, may be able to transmit the infection.* . It was admitted, however, that it was not known exactly how many of the HIV-positive donors were indeed "infected." [30]

Perhaps the CDC was so concerned about preventing the transmission of "HIV" that they did the same with blood screening: it is better to warn a large number of uninfected people about the possibility of transmitting a fatal infection than to allow a small number of infected people to spread the infection. However, this attitude ignores the devastating psychological effects on many uninfected people, who were thus condemned to believe that they had an incurable infection, with an inevitable fatal end.

However, the CDC went further than just "assuming" that being HIV-positive would automatically mean an infection. In 1986, in an article in JAMA (*Journal of the American Medical Association*), a much more widespread journal than the Weekly Mortality and Morbidity Reports (in which they published the "assumption"!), CDC researchers already defined "HIV-positive" as "HIV-positive." being "equivalent to being infected." [33]

As Richards [28] pointed out, all the cited data reported that the virus could not be cultured (respectively detected) in a large number of HIV-positive people. However, the CDC ignored this evidence, declaring that seropositive would mean "infected," although culturing the virus should in theory be a direct demonstration of infection, and the response to antibodies could be at most an indirect indicator of a possible "infection." ".

The CDC continued to waive any restrictions, declaring that "the presence of antibodies would indicate an infection" [34] , but not as a precautionary measure in screening or to prevent transmission, regardless of whether high-risk or low-risk and whether or not those people had symptoms. It was simply dogmatically decreed, without exception, that "HIV-positive" would mean "infected." Here we have a clear case of malpractice in the field of public health, based on a non-existent "science".

Moreover, Richards [28] pointed out that the CDC was in breach of its public health rights by this statement, in stark contrast to the FDA, which was responsible for consumer protection, and which had stated only a few months earlier that: "The *significance of antibodies in an asymptomatic individual it is not known.* " [35]

There is no "gold standard" for "HIV" tests

So far, we have analyzed the situation and the scientific work of the '80s. Have all these deficiencies been corrected? Simple and indisputable, the answer is: NO!

On the one hand, all subsequent work was based on the original articles. On the other hand, today's experts know for sure that a positive "HIV" test does not in itself mean proof of an infection, whether we are talking about ELISA, Western Blot, "viremia" or cultivation. It's just that this state of affairs is only communicated in the literature.

The following quote is taken from the chapter written by Weiss and Cowan in the fourth edition of the standard textbook, which can be considered an authority for several reasons: Weiss has worked in this field from the beginning, publishing since 1984, including with Gallo; the manual received

" *In the absence of the gold standard, the true sensitivity and specificity for the detection of antibodies to 'HIV' remains somewhat inaccurate.* "(P. 150)

Obviously, the expression " *somewhat* " is a euphemism: the **lack of the "gold standard" makes any statement or test extremely dubious** . Pure HIV virions, the "sine qua non" condition for setting a standard, have never been obtained from an AIDS or HIV-positive patient.

25 years of research into "HIV / AIDS" have not produced a valid "HIV" test. Weiss and Cowan clearly demonstrate that the "deduction" of an "HIV" infection is a matter of probability and not a certainty, and the identification of probability requires a combination of laboratory results and clinical information, including the patient's medical history and classification. one of the risk categories.

They also add:

" *Probability assessment before testing is necessary for the correct interpretation of tests* (p. 149). *An essential part of the testing procedure takes place before the test is performed, namely estimating the probability of infection (pre-test probability). This is necessary in order to be able to properly interpret the test result, depending on the purpose (clinical, counseling or research), and has a dramatic impact on the predictive value after the test (post-test probability) "* (p. 159).*"According to the same manual, no test alone can be a basis for diagnosis, but rather an aid to a correct diagnosis; the practitioner must use the test results in the context of the clinical picture to obtain a correct diagnosis* " (p.172) [3]

The importance of these uncertainties is illustrated in a table [3] (p.149) which shows that in the low-risk population group (HIV prevalence below 0.1%), a positive result of an HIV test has only one chance out of six to be a real positive; five out of six results are "false positive". On the other hand, at a prevalence of 99.9%, a negative result will have only one chance out of six to be really negative, and once an individual has been classified as a "high risk", not even a single An HIV-negative test can no longer be accepted as proof that there is no infection, so additional tests are recommended.

This illustration is based on a hypothetical test that would be 99.5% sensitive and 99.5% specific, but no test is 100% sensitive and specific. Thus, the "belief" that a person belongs to one or another of the risk groups massively influences the interpretation of laboratory tests and tends to become a "self-fulfilling prophecy."

conclusions

There is no gold standard for "HIV" tests. Current practice is to consider positive tests as evidence of an active infection, although antibody tests have been shown not to be specific for "HIV" antibodies, and it has been shown that the presence of "HIV" antibodies does not mean an active "HIV" infection. ", But eventually shows at most an exposure and a certain degree of immunity [*cf. allopathic dogma - nt*].

The consequence: healthy people are unjustifiably sentenced to lifelong toxic drugs. This is especially true for people included in the so-called "high risk categories". Outside Africa, these categories include homosexuals and intravenous drug addicts, as well as patients with tuberculosis, and more recently pregnant women should be included in a risk category because in their case false positive results appear very often.

In recent years, people of color in all social and economic categories in the United States have begun to be included in the high-risk category, as African Americans come a t "positi v" on "HIV" tests more often than other gro ps

The risk of iatrogenic injuries [*caused by doctors*] must always be considered by applying "HIV" tests correctly .

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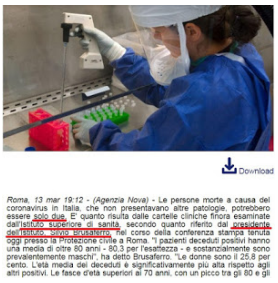

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